

NEW HAMPSHIRE LOCAL GOVERNMENT CENTER

HEALTHTRUST

BENEFITS OVERVIEW



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CARE • QUALITY • COMMITMENT • VALUE



In these days of challenging economies and healthcare environments, it's nice to know that there is one member-driven organization in New Hampshire that remains constant in its pledge to serve public sector employees through a team of dedicated professionals who are second to none: New Hampshire Local Government Center (LGC).

Our highly qualified employees know what it takes to provide exemplary service—from staffing our Member Care Call Center with a can-do-for-you attitude to providing worksite educational sessions aimed at helping you make the most of your healthcare benefits.

Please take the time to read this benefits overview carefully to learn about all the medical plan options that are available to you and your loved ones through LGC's HealthTrust. We look forward to your membership and serving you in the days ahead.

Wendy Le Parker



WHO WE ARE

New Hampshire Local Government Center (LGC) is a nonprofit organization dedicated to serving the public sector. Located in Concord, our history dates back to 1941 when New Hampshire Municipal Association (NHMA) was founded by a group of selectmen and city officials to effectively meet the developing needs of local government. In 1984, LGC HealthTrust was created to provide employee benefits to New Hampshire schools, municipalities, counties and other quasi-municipal entities. Today, more than 100,000 New Hampshire public sector employees, retirees and eligible family members enjoy our comprehensive array of employee benefit offerings, including medical, dental and prescription drug benefits, award-winning health and safety programs plus life, long-term and short-term disability coverage.

The LGC is governed by a 31-member board of directors comprised of municipal, school and county representatives, which include labor, management and elected officials. In addition to focusing on employee benefits, LGC has established a Property-Liability Trust and Workers' Compensation Program—both committed to serving the Granite State's public sector by providing a wide variety of risk and benefit management programs aimed at fostering a safe and healthy workforce.

This overview provides general information about medical plan options available through LGC HealthTrust. You will receive a plan certificate and cost-sharing schedule, specific to your medical plan, upon enrollment.

PLAN OVERVIEW

Understanding Medical Plan Basics

Upon enrollment into any LGC HealthTrust medical plan, members will receive a plan certificate and cost-sharing schedule. Always refer to these first for your plan's specific details. The following is general information about the medical plan options available through LGC HealthTrust.

All LGC HealthTrust plans provide the following benefits.

Comprehensive Features. These include:

- An extensive provider network.
- Office visits that are covered after a reasonable copayment—without any claim forms.
- Medical and surgical care.
- Inpatient hospital care.
- Preventive services coverage, such as routine physical examinations (covered at 100 percent following your copayment) and immunizations (covered in full).
- Worldwide coverage for emergency and urgently needed care.

Comprehensive Prescription Drug Coverage. All medical plans include prescription drug benefits that support your overall health, treat illness or chronic disease and manage pain.

- **Short-Term Prescriptions:** Members enrolled in a Matthew Thornton BlueSM Health Maintenance Organization (HMO) or *BlueChoice*[®] Point-of-Service (POS) plan receive a prescription drug card through CVS Caremark for purchasing short-term prescriptions at a retail pharmacy.



A copy of the *Your Prescription Benefit* booklet, which outlines your specific prescription drug benefits, will be provided upon your plan enrollment.

A 34-day supply of short-term medication can be purchased at a retail pharmacy for one copayment.

Indemnity plan members have access to WellPoint Rx, Anthem Blue Cross and Blue Shield's (BCBS) prescription drug benefit, and use their medical plan ID card for filling short-term prescriptions at the pharmacy.

- **Long-Term Prescriptions:** All members have access to the *CVS Caremark Mail Service Program*. Convenient and easy to use, the mail service program offers a 90-day supply of maintenance medication for one copayment.

Coverage While Traveling. When you need care while traveling, you can be assured that you'll receive the same level of benefits that you would at home when you obtain care from any Anthem BCBS network provider.

Managed Care

All of the medical plan options available to you include managed care features. Managed care ensures that you receive the appropriate care at the time you need it; managed care also works to improve the quality of that care. An indemnity plan with managed care requirements requires you to take a more active role in participating in your healthcare. It is your responsibility to ensure that you abide by the required managed care guidelines when you receive certain services from a provider who does not participate in the Anthem BCBS network or from any provider outside of New Hampshire.

Matthew Thornton Blue HMO

By managing members' total healthcare within a network and emphasizing preventive care, an HMO is easy-to-use and generally offers the least in out-of-pocket costs. A Primary Care Provider (PCP) selected from the network coordinates the majority of your care, ensuring consistency and continuity of care.

Selecting a PCP. A PCP is considered the main source for all healthcare, including referrals and claims processing. They are, generally speaking, the person seen first for all your medical care. One PCP can be chosen for your entire family (such as a family or general practitioner) at the time of your plan enrollment, or different PCPs can be selected for each person (such as a pediatrician for children).

To change a PCP once enrolled, please log onto www.nhlgc.org and click on HealthTrust—MyBenefits > Provider Directories > Anthem Blue Cross and Blue Shield Provider Directory. Select “New Hampshire” (for State/Directory), “Matthew Thornton Blue” (for Plan Information) and “Physicians” (for Provider Type). Be sure to check the “Able to serve as my Primary Care Provider” box. You can then search for local provider listings with phone numbers and addresses. Information on network behavioral health (mental and substance abuse) providers, vision providers and other specialists can also be found there.

Coordinated Care. While your PCP coordinates most care, there are times when another specialist, healthcare professional or hospital may be required. In these cases, your PCP will develop a treatment plan, refer care to an appropriate medical professional and make sure care is appropriate and medically necessary. Remember that *your PCP must provide, authorize or arrange for medical care—otherwise, care received without a referral is not covered*. There are exceptions. While routine OB/GYN services, maternity care, routine vision care and chiropractic services do not require PCP approval, a network provider must be utilized to receive benefits.

Emergency/Urgent Care. An *emergency* is a sudden condition that could jeopardize life or well-being if medical treatment is delayed. Examples include possible heart attacks, broken bones and convulsions. In an emergency, go *to your nearest emergency room and notify your PCP within 24 hours of receiving treatment*.

Urgent care refers to medical conditions that are not life- or limb-threatening but require prompt medical attention. Examples include high fevers, cuts and sprains. To receive the highest level of benefits in an urgent care situation, do the following:

- Call your PCP, regardless of the time of night or day.
- Explain the problem to the doctor or nurse.
- Get instructions on how to proceed.

With urgent care, a call to the PCP must be made first to ensure that care will be covered.

BlueChoice POS Plans

BlueChoice POS Plans let you take advantage of many attractive features that combine the freedom of a traditional plan with the cost savings of an HMO. Each time you need care, you may choose to see your PCP or visit another provider, which may increase the cost of your care.

Selecting a PCP. A PCP is considered the main source for all medical care, including referrals and claims processing. They are, generally speaking, the person seen first for all your medical care. One PCP can be chosen for your entire family (such as a family or general practitioner), or different PCPs can be selected for each person (such as a pediatrician for children).

How *BlueChoice* Works. Each time you need care, you decide whether to see your PCP or visit another provider—inside or outside of the *BlueChoice* network. Your choice determines how your care is covered:

1. *PCP-referred benefits.* When your PCP provides or coordinates your care, you pay the least in out-of-pocket expenses. For some services (such as physical exams, office visits, and vision exams), you receive 100 percent coverage with only an office visit copayment. For other services (such as hospitalizations and CT scans), your care is covered at the highest level for in-network care.

2. *Self-referred benefits.* If you choose to see a doctor without first seeing your PCP, or without a referral, you're still covered. Generally, if you choose to self-refer care directly from a *BlueChoice* participating provider, you have the least amount of out-of-pocket expenses associated with self-referred care. For care that is accessed directly from a provider who does not participate in the *BlueChoice* network, the cost of care is generally shared between you and the plan. You typically are responsible for a calendar-year deductible, as well as for a percentage of the cost of care up to a maximum out-of-pocket expense. Once you reach the maximum out-of-pocket expense, care is covered at 100 percent of the maximum allowable benefit* for the remainder of the calendar year. This option offers you the most freedom and control, and you still receive substantial benefits. However, you share in more of the cost for your healthcare services.

Emergency/Urgent Care. For emergency and urgent care situations, follow the same procedures previously outlined under the *Matthew Thornton Blue HMO* section of this booklet on page 5.

Indemnity Plans

Indemnity, or traditional fee-for-service plans, provide freedom of choice when accessing care. Members may choose their own doctors, arrange for covered medically necessary specialty care and select a hospital that meets their individual needs.

What's Covered. Indemnity plans are traditional medical plans that pay for covered medical services regardless of your choice of physician or hospital. You are covered for preventive care, routine doctor visits, hospitalization, prescriptions, surgery and more. Indemnity plans cover most care at 80 percent after

*A "maximum allowable benefit" is the amount that a medical plan allows for a particular service in your geographical area.



you meet a calendar-year deductible. When you reach a calendar-year out-of-pocket maximum, the plan pays 100 percent of eligible expenses for the remainder of the calendar year up to the maximum allowable benefit.*

Provided that you use a network provider, preventive care—such as routine exams, PSA screenings, annual gynecological exams, including mammograms and Pap tests and immunizations—is covered at 100 percent, up to the maximum allowable benefit.*

Accessing Care. When you or a covered family member needs care, simply go to the doctor or hospital of your choice. While indemnity plans do not require you to stay in a network, there are certain advantages to using an Anthem BCBS network provider:

- *No excess charges.* All indemnity plans pay healthcare claims based on your area's prevailing rates. Some doctors charge more than the prevailing rate. Anthem BCBS network providers agree to accept the plan's maximum allowable benefit. This means there aren't any excess charges that you are responsible for.
- *No claim forms or bills to submit.* Many providers ask you to pay up-front, then submit a claim for reimbursement. Anthem BCBS network providers agree to bill their services directly, which means you won't have to submit claim forms. Instead, you're billed only for your share of any covered expenses.

Preferred Provider Organization (PPO) Plan

What's Covered. The PPO medical plan allows the flexibility of accessing care from any network physician at any time, as well as the ability to directly access care from non-network providers.

Accessing Care. Selecting a PCP is not required for access to any care; however, lower out-of-pocket expenses are realized when using a network physician.

A PPO plan also allows specialty care to be obtained without a referral, but using a network specialist means less out-of-pocket costs. For preventive or routine care—typically provided during an office visit—only an office visit copayment applies. For more complex and expensive care like CT scans, MRIs or care received in an outpatient setting, you'd pay more for the cost of the care but still be protected from substantial out-of-pocket expense when you see a network provider.

When receiving out-of-network care, you share more in the cost of your care. You'd be responsible for more deductible and coinsurance expenses than you would from a network provider. However, you'd still have the security of an annual out-of-pocket maximum. Remember, though, that where you elect to receive your care—and who you choose to provide it—is your choice.

What's Important?

The cost of your medical plan is generally shared by you and your employer. Employee and employer contributions are not subject to federal income or Social Security taxes and generally are deducted from an employee's paycheck. Your contributions, as well as those of your employer, can be considerable. After reviewing your available medical plan options, consider the following to decide what is most important to you:

- Is my doctor in the network?
What about my gynecologist or my child's pediatrician?
- How do we normally access care?
Does our PCP provide and arrange for our care, or do we want to directly access care from providers outside of the network?
- How important is my contribution towards care? Can I absorb a higher office visit or emergency room copayment if my monthly contributions are reduced?
- What type of medications do we take?
Can we use generic medication?
- Do any of the plans provide programs for asthma, diabetes or other chronic conditions?
- Will I be impacted by any plan limitations?

While you can't predict all your future healthcare needs, it makes sense to consider the services you expect to need in the coming year and then evaluate your options. Once you've identified your needs, reviewing the overview of plans your employer has selected will be much more meaningful.

Consumer Driven Healthcare Plan

This plan is designed to give more options and control over healthcare. Health coverage is combined with a Health Savings Account (HSA), allowing direct access to care. HSAs are tax-favored accounts from which funds are drawn to pay for routine medical care, including prescription drugs. An HSA is funded with tax-free contributions by the employer, employee or a combination of both. Balances remaining at the end of the plan year are allowed to roll-over from one year to the next to pay for future healthcare needs, including coverage expenses in retirement.

Using Your Benefits

Know your benefits: Does your plan require a copayment or deductible/coinsurance? Be prepared to pay these amounts when accessing care.

Use your ID card: Be sure to provide a copy of your most recent ID card to your provider. Your ID card contains important identifying information that will be used to submit your claim.

Use network providers in order to limit your out-of-pocket expenses.

Use the emergency room only in an emergency when an illness is limb- or life-threatening. Emergency care is expensive and unnecessary for routine care/non-emergency care.

Keep everyone up-to-date by notifying both your employer and your plan of any changes to the following: address, coverage status, dependent eligibility or important life events like marriage or birth.





INCENTIVE PROGRAM

Because healthcare represents one of the most significant costs faced today, we all have a responsibility to help keep these costs under control. One way to assist is to monitor your provider bills and processed claims statements to ensure billing accuracy. You can do this by requesting and reviewing an *Explanation of Benefits** from Anthem BCBS, or by accessing your claims information online through the MyAnthem™ section of www.anthem.com.

With LGC HealthTrust's Incentive Program, you may be eligible to receive 50 percent of the savings for each claim error that is identified and corrected—up to \$1,000.

Here are steps to take for ensuring proper billing and claims processing:

1. Each time you receive medical care, obtain and study your itemized hospital/doctor bill or statement of services. Check for duplicate services or services not received.
2. Visit www.anthem.com. Click on “Login” to access the secure MyAnthem portal and then review and print “My Claims” information. Review and compare the online claims information—or the Anthem BCBS *Explanation of Benefits*—to the bill or statement of services from the provider. The following questions are just a few examples of what to consider:
 - a. Did you receive all the medical services you were billed for?
 - b. Did Anthem BCBS pay for any services you did not actually receive?
 - c. Did you have an outpatient procedure that was billed as an inpatient stay?



3. If you do find an error or discrepancy, report it to Anthem BCBS by calling the “Member Services” toll-free phone number listed on the back of your medical plan ID card. You can also write to: Anthem Blue Cross and Blue Shield, Claims Department, PO Box 533, North Haven, CT 06473-0533. Anthem BCBS will investigate the discrepancy and, when appropriate, reprocess the claim.
4. Once the claim is reprocessed, submit a copy of both the original and corrected *Explanation of Benefits*, or the printed claims payment from MyAnthem, plus a completed *LGC HealthTrust Incentive Program Reimbursement Request Form*** to: New Hampshire Local Government Center, LGC HealthTrust Incentive Program, PO Box 617, Concord, NH, 03302.

NOTE: You may be mailed Internal Revenue Service Form 1099 for any paid incentive received that is not considered tax-exempt.

*Anthem BCBS only provides *Explanation of Benefits* forms for services that require an employee cost share beyond a copayment. However, you can log into MyAnthem anytime to review all of your claims history or request an *Explanation of Benefits*.

**Downloadable from the “HealthTrust—MyBenefits” section of www.nhlgc.org or call 800.527.5001 to request a form.

VISION CARE



You and your family can access quality, discounted eye care services through EyeMed Vision Care. Its network of more than 35,000 providers nationwide includes private practicing optometrists, ophthalmologists, opticians and leading optical retailers like Target Optical, LensCrafters and Pearl Vision.

Receiving your discount—up to 35 percent off name-brand eyewear—is as easy as visiting your EyeMed provider. To locate the nearest participating provider, call **866.939.3633** or visit www.eyemedvisioncare.com to access EyeMed’s “Locate a Provider” web feature. Select “Access” for your network and enter your zip code.

Enrollment in the vision care discount program is automatic once you are enrolled in an LGC HealthTrust-sponsored medical plan. Using the discount program is easy—just present your ID card anytime you visit an EyeMed provider and take advantage of the discounts offered.

EYEMED ACCESS PLAN D

Overview:

The EyeMed Access Plan D is a discount-only plan providing reduced fees for exams, frames, lenses and contact lenses. The fees apply when a complete pair of eyeglasses is purchased; otherwise the discount is 20% off the retail price. All discounts are provided at the point-of-service and the frequency is unlimited.

The features of the EyeMed Access Plan D include:

- Access to one of the largest provider networks in the industry
- Choice of any available frame
- Unlimited frequency

Vision Care Services	Member Benefit
Exam with Dilation as Necessary:	\$5 off comprehensive exam \$10 off contact lens exam
Complete Pair Eyeglass Purchase Discounts*:	
-Frame, lenses and lens options purchased in same transaction	
Frames:	
Any available frame at provider location	35% off retail price
Standard Plastic Lenses:	
Single Vision	\$50
Bifocal	\$70
Trifocal	\$105
Lens Options:	
UV Coating	\$15
Tint (Solid and Gradient)	\$15
Standard Scratch Resistant Coating	\$15
Standard Polycarbonate	\$40
Standard Anti-Reflective Coating	\$45
Standard Progressive (Add-on to Bifocal)	\$65
Other Add-Ons and Services	20% off retail price
Contact Lenses: (Discount applies to materials only)	
Conventional	15% off retail price
Laser Vision Correction:	
Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price
Frequency:	
Examination	Unlimited
Frame	Unlimited
Lenses or Contact Lenses	Unlimited

*Frame, lenses and lens options discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, you receive 20% off the retail price.

This plan is in effect through December 31, 2011. You will receive a 20% discount on items not covered by the plan at in-network providers. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. The discount does not apply to professional services or contact lenses. Lost or broken materials are not covered. After initial purchase, replacement contact lenses may be obtained via the Internet at great prices and mailed directly to you.

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TRANSITION AND SURVIVOR CARE

– HOW IT WORKS

The death of a family member is a trying and stressful time. Often, in the midst of grief, survivors are forced to make critical decisions—financial, housing and caregiving choices that are difficult enough in the best of times. At LGC HealthTrust, we don't want health benefits to be one of those difficult choices. That's why we provide *Transition Care* and *Survivor Care* plans which allow us to continue providing medical and/or dental benefits to your covered family members at no charge until they are eligible for other coverage or their eligible coverage period ends. See the following descriptions of how each plan works.



TRANSITION CARE

If you die while an active employee, *Transition Care* allows your covered family members to continue their LGC HealthTrust-sponsored medical and/or dental plan coverage through your employer at no cost for a temporary period until they can explore other coverage opportunities.

Transition Care works in conjunction with COBRA* and your employer's retiree coverage policy. Respectful of the trust you have placed in us, we have developed the *Transition Care* benefit to pay the required contribution for your surviving covered family members for COBRA or retiree coverage for up to 12 months after your death.

*Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, is a federal law that allows covered eligible dependents to continue their group medical and/or dental coverage, generally at their own expense, in the months following the death of a covered employee.

Eligibility

In order to be eligible for *Transition Care* benefits:

- At the time of your death, you and your eligible dependents must have been enrolled in an LGC HealthTrust-sponsored medical and/or dental plan.
- At the time of your death, you must have been covered through your employer's LGC HealthTrust-sponsored plan as an active employee. Retirees or COBRA beneficiaries are not eligible for *Transition Care* benefits.
- Dependents must be eligible to continue existing medical and/or dental plan coverage upon your death in accordance with COBRA or your employer's retiree policy and must enroll according to applicable enrollment guidelines and timeframes.
- Your death cannot be the result of an act of war or terrorism.

Obtaining Extended Coverage

To take advantage of *Transition Care* benefits, your family members must notify your employer of your death and elect COBRA or retiree coverage.

Length of Benefits

Transition Care benefits will pay for up to the first 12 months of your covered dependents' COBRA or retiree coverage. This period allows your family to delay making a long-term decision about their

medical and/or dental coverage, allowing them to focus on more important needs without risking a lapse in coverage. By giving your family the benefit of time, your loved ones will be able to better research their medical and/or dental options.

Transition Care benefits will end prior to the end of the maximum 12-month period upon the earliest occurrence of any event listed below:

- Any event resulting in the termination of your covered family member's eligibility for COBRA or retiree coverage
- Your employer's participation in an LGC HealthTrust-sponsored medical and/or dental program is cancelled or voluntarily terminated
- Surviving spouse remarries – in which case:
 - ✧ Your surviving spouse loses *Transition Care* benefits, but COBRA coverage may continue at the surviving spouse's expense
 - ✧ Dependent children would also lose *Transition Care* benefits unless they remain eligible for a New Hampshire Retirement System (NHRS) subsidy (**NOTE:** A dependent child losing *Transition Care* benefits may continue COBRA coverage at their own expense.)

If your surviving spouse dies while on *Transition Care*, covered dependent children will be eligible to continue receiving *Transition Care* benefits.

When Benefits End

If your family members choose to retain their LGC HealthTrust-sponsored coverage after their eligible *Transition Care* benefit period ends, they will continue to be enrolled in COBRA or retiree coverage and follow applicable coverage requirements and regulations. COBRA coverage may be available for up to 36 months. This means that your family may be eligible for the remaining COBRA period, upon completion of their *Transition Care* benefit.

For the remaining COBRA period, your family may be responsible for paying up to 102 percent of the contribution cost of their coverage. Retiree coverage may be available to your covered family members as outlined by your employer group's and LGC HealthTrust's retiree coverage rules.

Benefits Coordination with COBRA, Retiree, Survivor Care and Other Coverage

It is important for *Transition Care* beneficiaries to review options and make timely decisions regarding other coverage opportunities during the *Transition Care* period. *Transition Care* beneficiaries should keep in mind that other coverage options available through another group medical plan may have different open enrollment timelines.

Transition Care beneficiaries who are eligible for *Survivor Care* benefits (described on pages 15-16) can be transferred to those benefits after completing their maximum 12-month *Transition Care* benefit.

IMPORTANT: If a member group changes coverage options during a covered dependents' *Transition Care* period, coverage for *Transition Care* benefits are subject to the coverage change.

Beneficiary Obligations

➤ NHRS subsidy eligibility and changes

- Family members who are, or become, eligible for a NHRS subsidy at the start of, or during, the *Transition Care* benefits period must obtain and apply the NHRS subsidy toward the *Transition Care* benefits.

➤ Eligibility and enrollment for Medicare Part B

- Family members who are or become eligible for Medicare Part B at the start of, or during, the *Transition Care* period must apply for and enroll in Medicare Part B. *Transition Care* benefits will change to a Medicare Supplemental Plan upon enrollment into Medicare Part B. Eligible dependents are encouraged to apply promptly for Medicare Part B benefits as untimely application could result in an enrollment delay as well as a higher lifetime Medicare Part B premium cost.

➤ Notification requirements

A *Transition Care* beneficiary must notify LGC HealthTrust within 30 days of the occurrence of the following events:

- *Transition Care* beneficiary becomes **eligible** under another group medical and/or dental plan that does not impose pre-existing condition exclusions applicable to him/her
- *Transition Care* beneficiary becomes eligible for Medicare (Part A, B or both) benefits
- A child no longer qualifies as a dependent under the plan
- Remarriage or death of the surviving spouse

Failure to notify LGC HealthTrust of these events in a timely manner will result in cancellation of the *Transition Care* benefits. Additionally, upon exhausting their *Transition Care* benefits, *Transition Care* beneficiaries eligible for *Survivor Care* benefits must acknowledge, in writing to LGC HealthTrust, their desire to obtain *Survivor Care* benefits.

SURVIVOR CARE

In the event of your death while performing your job responsibilities, *Survivor Care* allows your covered family members to continue their LGC HealthTrust-sponsored medical and/or dental plan coverage through your employer at no cost until experiencing an event that ends eligibility, such as becoming Medicare eligible.

Survivor Care works in conjunction with *Transition Care*, COBRA or your employer's retiree coverage policy. The *Survivor Care* benefit will continue to cover the required contributions towards coverage for your previously enrolled family members until certain cut-off events occur.

Eligibility

In order to be eligible for *Survivor Care* benefits:

- Your death must have occurred while you were performing your job responsibilities with an LGC HealthTrust member group and resulted in an eligible workers' compensation death claim.
 - Your surviving covered dependents must have been eligible for *Transition Care* benefits and exhausted those benefits.
 - Your surviving dependents cannot be Medicare eligible at the time *Survivor Care* benefits would otherwise commence.
 - Surviving spouses cannot have remarried prior to the time *Survivor Care* benefits would otherwise commence.
 - Surviving dependent children must meet the definition of dependent under the terms of your employer's medical or dental plan.
 - Your death cannot be the result of an act of war or terrorism.
- Your covered family members become eligible for Medicare (Part A, B or both) benefits
 - Your employer's participation in an LGC HealthTrust-sponsored medical and/or dental program is cancelled or voluntarily terminated
 - Your child no longer qualifies as a dependent under the plan (**NOTE:** Your child may have COBRA rights upon loss of *Survivor Care* benefits.)
 - Surviving spouse remarries – in which case:
 - ✧ Your surviving spouse loses *Survivor Care* benefits, but COBRA coverage may continue at the surviving spouse's expense
 - ✧ Dependent children eligible for an NHRS subsidy may continue *Survivor Care* benefits
 - ✧ Dependent children not eligible for an NHRS subsidy lose coverage and may continue COBRA at their own expense

If your surviving spouse dies, covered dependent children will be eligible to continue receiving *Survivor Care* benefits.

Length of Benefits

Survivor Care benefits may be available for 1.) your covered spouse until their Medicare eligibility and/or 2.) your dependent until they no longer meet the dependent definition. *Survivor Care* benefits will end sooner upon the earliest occurrence of any event listed below:

- Your covered family members become **eligible** for coverage under another group medical and/or dental plan that does not impose a pre-existing condition exclusion

IMPORTANT: If a member group changes coverage options during a covered dependents' *Survivor Care* period, coverage for *Survivor Care* benefits are subject to the coverage change.

Beneficiary Obligations

➤ NHRS subsidy eligibility and changes

- Family members who are, or become, eligible for a NHRS subsidy at the start of, or during, the *Survivor Care* benefits period must obtain and apply the NHRS subsidy toward the *Survivor Care* benefits.

➤ Eligibility certification

- A *Survivor Care* beneficiary must respond to semi-annual Eligibility Certification requests within 30 days.

➤ Notification requirements

A *Survivor Care* beneficiary must notify LGC HealthTrust within 30 days of the occurrence of one of the following event(s):

- *Survivor Care* beneficiary becomes **eligible** under another group medical and/or dental plan that does not impose any pre-existing condition exclusion applicable to him/her

- *Survivor Care* beneficiary becomes eligible for Medicare (Part A, B or both) benefits
- A child no longer qualifies as a dependent under the plan
- Surviving spouse remarries or dies (**NOTE:** Only surviving spouse loses *Survivor Care* benefits.)

Failure to notify LGC HealthTrust of these events in a timely manner will result in cancellation of the *Survivor Care* benefits.





HIPAA

PROTECTING YOUR PRIVACY AND ENSURING CONTINUED COVERAGE FOR PRE-EXISTING CONDITIONS

In 1996, Congress passed the *Health Insurance Portability and Accountability Act (HIPAA)*. This act is designed to make it easier for you and your family members to have continued medical coverage when changing from one employer to another.

Non-Discrimination Rules

With HIPAA, medical plans cannot have enrollment rules based on health factors. This means that a medical plan cannot require evidence of insurability (proof of good health) and cannot exclude individuals who cannot pass a physical exam (including late enrollees).

Special Enrollment Opportunities

If you decline coverage for yourself or your eligible family members because of other medical coverage, you may be able to enroll yourself or your dependents in your employer's medical plan in the future.

The following special enrollment opportunities are available:

Involuntary Loss of Coverage. You may be able to enroll yourself and your dependents if other coverage ends because of loss of eligibility through no fault of your own, because an employer's contributions for other coverage stop or, in the case of COBRA coverage, because the maximum COBRA period has expired. You must request enrollment in your employer's plan within 31 days of when your coverage ends.

New Dependents. You may be able to enroll yourself and your dependents if you have previously declined coverage and you have a new dependant as a result of marriage, birth, adoption or placement for adoption (a "qualified family status change"). You must request enrollment in your employer's plan within 31 days of the qualified family status change.

Loss of Coverage Under a Medicaid Plan or SCHIP.

You and your dependents may be able to enroll during the plan year if you or your dependent loses coverage under a Medicaid plan or under a State Children's Health Insurance Plan (SCHIP) due to loss of eligibility for such coverage. You must request enrollment under your employer's plan within 60 days of the date the other coverage is lost.

Eligibility for Assistance Under a Medicaid Plan or SCHIP.

You and your dependents may be able to enroll during the plan year if you or your dependent becomes eligible for state funded group health plan premium assistance through a state Medicaid program or SCHIP. You must request enrollment under your employer's plan within 60 days of the date you or your dependent is determined to be eligible for premium assistance.

If Your Coverage or Employment Ends

If your coverage through your employer's LGC HealthTrust-sponsored medical plan ends, or your employment terminates and you are eligible for coverage through COBRA, you and your qualified dependents will be provided a written certificate of coverage to give your new employer or medical insurer. This certificate helps determine if your new plan may impose pre-existing condition limitations. Be sure to keep this certificate when you receive it.

OUR PARTNERS

At LGC HealthTrust, we partner with the following highly respected companies to provide proven and innovative programs aimed at effectively meeting the needs of our members.

Anthem Blue Cross and Blue Shield – For more than 25 years, LGC HealthTrust members have enjoyed an expansive Blue Cross and Blue Shield provider network plus worldwide recognition of the trusted Blue Cross and Blue Shield name. Our members benefit from Anthem's ability to negotiate significant provider discounts (both in and outside of New Hampshire), due to its large membership base, as well as its long-standing expertise in claims administration, medical management and excellence in customer service support.

Northeast Delta Dental (Delta) – An LGC HealthTrust partner for nearly 25 years, Delta is locally based in Concord. Delta provides our members with an extensive local and national network of participating dentists, comprehensive benefits and exemplary customer service. Our members receive the most value by accessing care from a Delta participating dentist through their ease of administration, automatic claim filing and direct-to-dentist payment plans. Our members also have the freedom to receive services from any dentist they choose.

CVS Caremark – A commitment to safety and clinical effectiveness contributes to CVS Caremark's status as a leading provider of prescription benefit management (PBM) services for more than 25 years. The first PBM to be recognized for customer satisfaction excellence by J.D. Powers and Associates, CVS Caremark offers the value and service commitment our members have come to expect.

Gordian Health Solutions – A noted leader in health risk assessment, Gordian is LGC HealthTrust's partner of choice for providing proven programs like the *Get Healthy* Personal Health Analysis questionnaire and personalized health coaching to help our members live healthy and productive lifestyles.

EyeMed Vision Care – One of the leading managed vision care organizations in the industry, EyeMed administers a vision care discount program for LGC HealthTrust members with an emphasis on choice, quality, value and service excellence. Through EyeMed, our members have access to more than 35,000 vision care providers nationwide at popular retail locations like Target Optical, LensCrafters and Pearle Vision. (See page 11 for a complete overview of available EyeMed benefits.)

Health Resources – This leading provider of employee assistance programs administers the *LifeResources—Member Assistance Program* for LGC HealthTrust members. The program features comprehensive mental health and referral counseling services for issues such as stress management, addiction, parenting, eldercare, divorce and financial concerns.

National Insurance Services (NIS) / Madison

National Life (MNL) – We are pleased to partner with NIS, an organization that has served the public sector since 1969, in offering term life and long-term disability protection through MNL—rated A- (Excellent) for financial strength by A.M. Best Company.

All the benefits listed in this overview may not apply to your plan option. Please refer to the plan information sent to you upon your enrollment for your plan specifics.



www.nhlgc.org

800.527.5001 (NH toll free)
603.226.2861 (Concord area)

WEB AND PHONE RESOURCES

Please visit the “HealthTrust—MyBenefits” section of www.nhlgc.org for convenient links to web resources from LGC HealthTrust’s partners, plus the following:

- *eMember Services*—our interactive web feature that lets you securely submit forms electronically
- Helpful forms to download
- Details on upcoming workshops
- *Slice of Life* health management program information
- Frequently asked questions and answers
- *Slice of Life* newsletters with articles aimed at helping you become a smarter healthcare consumer



In New Hampshire, Anthem Blue Cross and Blue Shield is a trade name of Anthem Health Plans of New Hampshire, Inc., an independent licensee of the Blue Cross and Blue Shield Association. ® Registered marks of the Blue Cross and Blue Shield Association.

www.anthem.com

Contact Information:

BlueChoice: 800.438.9672

Matthew Thornton Blue:
800.870.3057

Indemnity Plans: 800.225.2666

New England Health Plans:
800.870.3122

Lumenos: 800.852.6592

Anthem Prescription:

www.anthem.com
800.225.2666

BlueCard® Program:

www.bcbs.com
800.810.BLUE (2583)



www.caremark.com
888.726.1631



www.GetHealthyTools.com
866.564.5237



Northeast Delta Dental
www.nedelta.com
800.832.5700



**LifeResources—
Member Assistance Program**

Details available at:
www.nhlgc.org
800.759.8122



www.eyemedvisioncare.com
866.939.3633



www.nis-sif.com



Local Government Center

New Hampshire Municipal Association
Workers' Compensation Trust
Property-Liability Trust
HealthTrust

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This brochure, a summary of programs and services, may be governed by separate policies. It does not constitute a contract, nor offer to form a contract, and is not binding on any party. New Hampshire Local Government Center may change the benefits described herein at any time without prior notice.